

LABOR DOULA CARE FOR SURVIVORS OF SEXUAL VIOLENCE

by

Lisa Sophia Haen

BA, Georg-August-Universität Göttingen, Germany, 2015

Submitted to the Graduate Faculty of
the Department of Behavioral and Community Health Sciences
Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2017

UNIVERSITY OF PITTSBURGH
GRADUATE SCHOOL OF PUBLIC HEALTH

This thesis was presented

by

Lisa Sophia Haen

It was defended on

December 08, 2017

and approved by

Thesis Director

Martha Ann Terry, PhD
Associate Professor, Behavioral and Community Health Sciences
Graduate School of Public Health, University of Pittsburgh

Committee Member

Mary Hawk, DrPH, LSW
Associate Professor, Behavioral and Community Health Sciences
Graduate School of Public Health, University of Pittsburgh

Committee Member

Elizabeth A. Winter, PhD, LSW
Clinical Assistant Professor, School of Social Work, University of Pittsburgh

Committee Member

Kim Gutschow, PhD
Associate Professor, Religion and Anthropology/Sociology, Williams College
Williamstown, Massachusetts

Copyright © by Lisa Sophia Haen

2017

LABOR DOULA CARE FOR SURVIVORS OF SEXUAL VIOLENCE

Lisa Sophia Haen, MPH

University of Pittsburgh, 2017

ABSTRACT

Objective: The goal of this study was to identify how labor doula care can support women who have experienced past sexual abuse in coping with trauma-related challenges and barriers during childbirth and avoid re-traumatization.

Methods: Three in-depth, face-to-face interviews with labor doulas were conducted. The interviews were transcribed and coded. The data aligned with the five key themes of the Good Birth framework which are personal security, knowledge, connectedness, respect, and agency. This framework was applied post-hoc for the analysis.

Results: Participants gave comprehensive insights as to how continuous labor support as provided by doulas can assist survivors of sexual violence cope with and mitigate trauma-related challenges, triggers and barriers during childbirth. The five key themes of the Good Birth framework categorized the doulas' non-medical scope of practice which can improve birth experiences and outcomes for survivors of sexual violence. The significance of patient-led disclosure as well as the current status quo of the maternity care system was also discussed.

Conclusions: Birth experiences and maternal satisfaction can be facilitated through labor doula care which may enhance a survivor of sexual assault's personal security, knowledge, connectedness, respect and agency. The public health significance of this research is that it examines labor doula support for survivors of sexual violence and how this form of nonmedical assistance can mitigate and buffer the impact of trauma-related challenges, in an effort to decrease adverse birth outcomes affecting survivors of sexual violence and their children.

TABLE OF CONTENTS

1.0	INTRODUCTION	1
2.0	PREVALENCE OF SEXUAL VIOLENCE	4
2.1	CHILDHOOD SEXUAL ABUSE.....	5
2.2	ADULT SEXUAL ABUSE.....	7
3.0	IMPLICATIONS FOR MATERNITY CARE	10
3.1	PREGNANCY AND BIRTH	16
3.1.1	REMEMBERING.....	18
3.1.2	CONTROL	20
3.1.3	DISSOCIATION.....	23
3.1.4	HEALING.....	24
3.2	BENEFITS OF DOULA CARE	25
3.2.1	EFFECTS ON PHYSICAL LABOR OUTCOMES	29
3.2.2	EFFECTS ON MENTAL WELL-BEING.....	29
3.2.3	ECONOMIC BENEFITS.....	30
3.3	DOULA CARE AND SURVIVORS OF SEXUAL VIOLENCE	32
4.0	RESEARCH QUESTION.....	33
4.1	METHODS.....	33

4.1.1	STUDY PARTICIPANTS AND RECRUITMENT	34
4.1.2	DATA	35
4.1.3	ANALYSIS	35
4.2	RESULTS	36
4.2.1	KEY THEMES ALIGNING WITH GOOD BIRTH FRAMEWORK.....	37
4.2.1.1	PERSONAL SECURITY.....	37
4.2.1.2	KNOWLEDGE	39
4.2.1.3	CONNECTEDNESS	41
4.2.1.4	RESPECT.....	42
4.2.1.5	AGENCY.....	43
4.3	DISCLOSURE.....	45
4.4	CURRENT CLINICAL ENVIRONMENT	47
4.5	DISCUSSION	49
4.5.1	IMPLICATIONS FOR POLICY	51
4.5.2	IMPLICATIONS FOR PRACTICE	52
4.6	LIMITATIONS	53
5.0	CONCLUSIONS.....	54
	BIBLIOGRAPHY	55

1.0 INTRODUCTION

Sexual abuse is considered a major public health issue (Finkelhor 1994). Research has shown that sexual violence can be a severely traumatizing experience that may lead to a wide variety of significant adverse physical and mental health outcomes, including posttraumatic stress disorder, substance abuse, depression, eating disorders, chronic pains, risky sexual behavior and sexual dysfunction, among others (Heritage 1998; Lukasse et al. 2009; Nerum et al. 2010). In addition, for primiparous women who have experienced sexual assault, pregnancy and childbirth can pose complicated challenges, such as re-traumatization and severe fear of labor and birth. Studies have also highlighted that survivors of rape show an increased risk of cesarean sections and assisted vaginal deliveries, as well as a longer second stage of labor (Nerum et al. 2010). An association between childhood sexual abuse and an increased reporting of common pregnancy complaints, e.g. heartburn, tiredness, and backaches, was found by Lukasse et al. (2009). Furthermore, Leeners et al. (2010) described that survivors of childhood sexual abuse were not only more likely to experience complications, e.g. cervical insufficiency or premature contractions throughout pregnancy, but their average number of complications was significantly higher compared to women with no history of childhood sexual abuse. Consequently, the affected women also showed a higher hospitalization rate.

The adverse health outcomes associated with the experience of sexual violence can disrupt a mother's ability to tend to her child's emotional and physical needs, thus affecting the

mother-child dyad and bond. Children of women who have a history of sexual abuse are also more at risk to suffer from depressive symptoms and experience neglect or abuse themselves (Egeland et al. 1998; Roberts et al. 2015)

It is evident that survivors of sexual violence can experience specific trauma-related challenges regarding childbearing and may demonstrate unique health care needs during pregnancy and childbirth. Based on the high prevalence of childhood and adult sexual abuse, giving affected women a voice is crucial. The birth experiences of these women cannot be dismissed.

Research also needs to consider the experiences of the various forms of maternity professionals to help reform services and care. Other than recommendations for medical health care providers to inquire about trauma history and treat survivors with respect, patience and sensitivity, the current evidence base is lacking sufficient exploration of alternative forms of maternity care and support for childbearing survivors of sexual violence. A small body of research has examined the benefits of doula care for vulnerable populations, e.g. low-income or incarcerated women (Hotelling 2008), but so far has not explored different aspects of non-medical maternity care and support, and how this kind of assistance can help survivors of sexual violence achieve favorable childbirth experiences and maternal satisfaction. Considering the prevalence of sexual violence and its potential severe short and long-term adverse health effects on both mother and child, an improvement of the birth experiences and outcomes of survivors of sexual violence is of great public health significance and should no longer be ignored.

This thesis highlights and explores how labor doula care can support survivors of sexual violence to cope with trauma-related barriers and stressors as experienced during labor and delivery. To provide a comprehensive overview, common definitions of childhood and adult

sexual abuse and their prevalence are being presented. The lack of a universal definition of these two offenses as well as the complexities and stigma of reporting sexual abuse are also discussed. This thesis also examines the implications of sexual violence on maternity care and how pregnancy and birth can be affected by sexual violence trauma. Dominant themes discussed in the current literature are being identified. The positive effects of labor doula care on physical birth outcomes, mental well-being, and health care expenditures are discussed.

In efforts to understand how labor doulas can support survivors of sexual violence cope with trauma-related barriers and challenges during childbirth, this thesis presents findings from a research study for which three labor doulas were interviewed about their insights and experiences in working with women who have a history of sexual abuse.

2.0 PREVALENCE OF SEXUAL VIOLENCE

Approximately every 98 seconds, an American is sexually assaulted. Every eight minutes, a child is the victim of sexual abuse (United States Department of Health and Human Services 2012). Research published in 2007 showed that out of the 112 million women living in the United States, about 20 million, or 18%, have been raped during their lifetime (Kilpatrick et al. 2007). The National Intimate Partner and Sexual Violence Survey (NISVS) highlights that approximately 27% of women in the U.S have experienced some form of unwanted sexual contact in their lifetime (Breiding, Smith, Basile, Walters, Chen & Merrick 2014). One in five women will be raped at some point in their lives and in 80% of cases of sexual assault, the perpetrator was known by the victim (Black et al. 2011; Miller, Cohen & Wiersema 1996).

A study conducted by the Centers for Disease Control and Prevention (CDC) estimates that approximately one in four girls and one in six boys will be sexually abused before their 18th birthday (American Psychological Association, 2004; Finkelhor 1990). According to the Crimes Against Children Research Center and the National Crime Victimization Survey of the Department of Justice, sexual violence actually declined by 62% between 1992 and 2010 (Finkelhor & Jones 2012). It is likely, however, that the actual rate is much higher due to the sensitive nature of sexual violence as well as due to the complexities of reporting sexual assault. A study that examined the “below the surface” rates of childhood sexual abuse (Martin & Silverstone 2013 in women highlighted prevalence rates between 2% and 45% (Bolen &

Scannapieco 1999) while another study reported that 7% to 36% of women were affected by childhood sexual abuse (Finkelhor 1994).

According to another study by Finkelhor (2009), overall only 30% of sexual assault offenses are reported to official authorities. Due to underreporting, the actual prevalence of sexual violence is difficult to determine. Furthermore, sexual abuse and childhood sexual abuse lack universal definitions, which impedes research efforts and unison, hence, statistics may vary and are difficult to compare (Haugaard 2000).

2.1 CHILDHOOD SEXUAL ABUSE

Sexual abuse and violence directed towards children is a prevalent reality worldwide. The World Health Organization (WHO) defines childhood sexual abuse as:

the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performance and materials (WHO Consultation on Child Abuse Prevention 1999, p.16).

The CDC defines childhood sexual abuse as “any completed or attempted (non-completed) **sexual act**, **sexual contact** with, or exploitation (i.e. **noncontact** sexual interaction) of a child by a caregiver” (Leeb, Paulozzi, Melanson, Simon & Arias 2008, p.14). The bold-highlighted terms are specifically defined and differentiate abusive sexual contact as intentional touching without penetration, sexual acts as those involving penetration, and noncontact sexual abuse as taking sexual photographs or videos of a child, sexual harassment, prostitution, trafficking or exposing a child to other forms of sexual activity (Leeb, Paulozzi, Melanson, Simon & Arias 2008).

The sexual offense often engages the child in a gradual process of frequent, repeated episodes that become more invasive over time. Sexual assault of children is a complex and unique phenomenon as physical violence is only rarely used. Instead, the perpetrator tries to corrupt the child’s trust and self-awareness (WHO 2003).

Perpetrators often threaten and manipulate their victims to feel guilty or responsible for the assault which may delay a disclosure of the abuse (Murray et al. 2015). Children are developmentally vulnerable and may fear that they will not be believed or may worry about how the disclosure will influence their own well-being or that of their families.

According to the National Center for Juvenile Justice, in 93% of child sexual abuse cases reported to law enforcement, the child knows the perpetrator (Snyder 2000). Thus, as perpetrators often have developed some form of relationship with their victim, it is possible that the affected child also worries about any consequences for the perpetrator caused by disclosure, furthering the likelihood of underreporting (Murray et al. 2015).

2.2 ADULT SEXUAL ABUSE

Similar to childhood sexual abuse, sexual violence towards adults can take many different forms.

The CDC defines sexual violence as:

a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; non-physically pressures unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party. Sexual violence involves a lack of freely given consent as well as situations in which the victim is unable to consent or refuse (Basile, Smith, Breiding, Black & Mahendra 2014, p.13).

Coercion and pressure include a wide variety of force, e.g. physical force, psychological intimidation, degradation, abuse of authority, threat of physical harm, exploitation of vulnerability, or other threats such as economic coercion (Basile, Smith, Breiding, Black & Mahendra 2014). Underlying reasons for sexual violence are often control and power, and not a craving for sexual pleasure as might be assumed (Coomaraswamy 1997). In the majority of cases, it is not a crime of passion, but rather an aggressive, violent offense to degrade, humiliate and control the victim. This form of hostility is meant to disintegrate and control the victim's notion of their self (Groth 2000).

Data on the prevalence of sexual violence often come from law enforcement authorities, clinical settings, survey research and nongovernmental organizations. However, current available

data are scarce and often fragmented. Only 37% of sexual assault offenses are reported to police, thus, it is a significantly underreported crime due to multi-faceted, complex reasons (Rennison 2002). Many women do not report sexual assault because they are embarrassed or scared to be blamed, ridiculed or not believed (Kilpatrick 2011). Furthermore, only a small number of women trust official authorities and hence, do not seek immediate medical services for urgent problems caused by sexual violence, which makes data collection difficult. Some data are also more focused on more violent forms of sexual abuse and differentiate sexual assault from rape (WHO 2003).

There has been a significant increase in the discussion of sexual violence in both the domestic and global context, and the complexities of sociological concepts such as rape culture are gaining more recognition and awareness. Research has also made noticeable advances in measuring the prevalence of sexual violence and its effects; however, a universal definition is lacking across studies. What constitutes sexual assault and the willingness to disclose the experiences of such offenses to both official authorities and researchers also vary greatly across cultures and societies (United Nations Interregional Crime and Justice Research Institute 1998).

Despite the methodological difficulties of research as well as the high variability in current prevalence, sexual violence is considered a major complex public health problem. Even though sexual violence seems to be omnipresent, many affected women feel isolated, stigmatized and ashamed about what has happened to them (Leeners et al. 2006; Seng et al. 2002). The traumatic experiences may leave them feeling unsafe and alone, and survivors often show a desire to regain control (Garratt 2002; Simpkins 2006). However, many health care settings resemble the location of the abuse and can therefore be triggering and cause a re-traumatization of the survivor. An anxious patient is often labelled by many providers as ‘difficult’ and

uncooperative and is not treated empathetically (Garratt 2002; Rouf 1999). Maternity care in particular involves certain triggers, e.g. pelvic exams and can significantly influence how a survivor of sexual abuse feels towards pregnancy, labor, delivery and the postpartum period (Garratt 2002; Rose 1992).

3.0 IMPLICATIONS FOR MATERNITY CARE

Childbearing survivors of sexual abuse are at greater risk to have higher stress levels during pregnancy and are consequently more likely to go into labor prematurely. It has also been shown that affected women had fewer prenatal consultations and experienced their pregnancy and childbirth as more difficult, compared to their controls (Benedict, Paine, Paine, Brandt & Stallings 1999; Leeners, Rath, Block, Goerres & Tschudin 2014). A longer second stage of labor as well as increased medical problems and pregnancy complaints are more common for women who have experienced sexual abuse (Jacobs 1992).

Women can remember their birthing experiences clearly and recall vividly what happened, what was said and done to them and how they felt emotionally and physically (Simkin 1992). The feeling of being in control and treated with empathy and respect was more important than physical and clinical features of the delivery process (Simkin 1992). Even 20 years later women who recalled their birth experience as very satisfying remembered being an active participant, in control and well supported by attending maternity care staff (Bramadat & Diedger 1993; Simkin 1992). Birth was perceived as an experience that made them feel accomplished, confident and proud. Women who perceive their experience of childbirth as less satisfying tend to feel the opposite (Simkin 1992). Thus, it is evident that the way women are treated during childbirth can affect their emotional and physical well-being as well as their confidence and self-perception for the rest of their lives. However, birth advocate Madsen Wagner has deemed the

United States' maternity care system as broken and negligent, failing to empower women and prioritize informed, patient-centered care practices (Wagner 2006).

Due to its high prevalence, childhood and adult sexual abuse is an obstetrical risk factor whose significance is equal to other, often more thoroughly studied causes of pregnancy complications such as gestational diabetes or hypertension (Leeners et al. 2010). Furthermore, the trauma of childhood sexual abuse can also negatively affect the postpartum period. Studies have recognized that mothers who were sexually abused as children tend to feel more confused about healthy family dynamics. They may also be more insecure in their abilities to trust appropriately which can increase interpersonal conflict, as well as internal stress on the mother and external stress on her offspring (Polusny & Follette 1995; Schore 2001). Children of women who have a history of childhood sexual abuse are more likely to suffer from depressive symptoms compared to children whose mother has not been sexually abused during childhood (Roberts et al. 2015).

Marysko et al. (2010) show that adult female survivors of childhood sexual abuse can experience a heightened number of dissociative experiences throughout the first year after childbirth which can negatively affect the mother-child dyad and bond. As mothers who have a history of childhood sexual violence and higher levels of dissociation are more likely to abuse or neglect their own children (Egeland et al. 1988; Noll, Trickett, Harris & Putnam 2009), Marysko et al.'s (2010) findings are crucial for preventive efforts. Furthermore, survivors of childhood sexual abuse can frequently experience the trauma's negative emotional effects, e.g. depression, dissociation, anxiety and other mood disorders, throughout adulthood which can disrupt the mother's presence and ability to tend to her child's emotional and physical needs (Duncan 2005). Attachment Theory is applicable to this context as it argues that maternal detachment can be

traumatic for children and impact their neurological, emotional, and social development (Main 1996).

Integrating knowledge of sexual abuse and its effects on childbearing into prenatal, maternity and postpartum care can thus result in risk mitigation and overall better birth outcomes, and treatment of affected patients, as well as improved maternal-child bonding and infant development (Leeners et al. 2010). However, many women do not disclose their history of sexual abuse to their maternity care provider (Cawson et al. 2000; Montgomery 2012). In particular, women who have been sexually assaulted in childhood have often buried the memories of the abuse and do not actively recall the painful events (Garratt 2011; Parrat 1994; Simkin & Klaus 2004). The emotional and physical changes of pregnancy and childbearing can often be triggers that cause memories of the event to resurface (Simkin & Klaus 2004).

Women who do remember being assaulted may decide not to disclose their history because they fear ridicule, blame, and invalidation or rejection of their feelings (Hulme 2000; Maheux et al. 1999; McGregor 2003). In some European studies, only 0.5-6% of survivors had talked to their gynecologist about their abuse experiences (Peschers, Du Mont, Jundt, Pfurtner, Dugan & Kindermann 2003; Wijma et al. 2003).

A study by Seng et al. (2002) found that women were scared of being judged and needed rapport with their maternity care provider as well as trust that their providers will respond to disclosure with empathy, concern and confidentiality. Most maternity care professionals, however, are often bound to a hectic schedule. Even though they usually do see their pregnant patients frequently for prenatal checkups, the majority of interactions are focused on the clinical and physiological factors of fetal development, pregnancy and childbirth, and only a little time is dedicated to the emotional and psychological aspects.

Even though the American College of Obstetricians and Gynecologists (ACOG) recommends that its members to initiate conversations about experiences of sexual violence with their patients, the most frequent reason for low disclosure rates is the lack of inquiry about sexual traumatic experiences by health care providers (ACOG 2011; Edwards, Anda, Felitti & Dube 2004; McGregor 2003; Read et al. 2006). Inquiry rates of obstetrician-gynecologists have been reported to be as low as 2% (Maheux et al. 1999).

A lack of disclosure can result in negative patient experiences, especially during gynecological and obstetrical examinations and procedures. Studies have shown that pelvic exams are more uncomfortable and traumatizing for survivors of sexual abuse (Hilden, Sidenius, Langhoff-Roos Wijma & Schei 2003; Leeners et al. 2007). A provider who does not inquire about a patient's history of sexual abuse may unintentionally exacerbate a survivor's notion that the abuse experience and its effects may not matter or have medical significance (Holz 1994). Considering the interplay of the lack of disclosure and the providers' lack of inquiry, women who have experienced sexual trauma are more vulnerable to poor patient experiences as the provider is unaware of needing to modify their care techniques to adjust to the survivor's needs and concerns. Even though inquiry about histories of sexual abuse does not seem to be the status quo, women want maternity care provider to ask about a history of sexual abuse, even though they are not always ready to disclose their experiences (Palmer 2004).

As the interaction with maternity care staff is a significant factor in maternal satisfaction of pregnancy and childbirth experiences, the caregivers' response to a disclosure of past or present sexual abuse is crucial in the dynamics of the doctor-patient relationship (Schachter et al. 2004). Care professionals who seemed to be prepared to discuss the difficult and complex issues of sexual abuse and its effects on pregnancy and childbirth were preferred by the study

participants. Unfortunately, disclosure was not always met with empathy and understanding (Burian 1995; Coles & Jones 2009). Care staff should by no means downplay or dismiss a patient's experience of sexual violence and its effects. A study highlighted that 97% of its participants who have experienced childhood sexual abuse have received unfavorable, dismissive reactions from their physician to their disclosure of abuse, e.g. silence, doubt about abuse, denial that the experience of abuse will influence current medical care, and shocked expression without any follow-up or referral (White 2004). In general, but especially considering the authoritative hierarchy of the doctor-patient relationship, such insensitive responses to disclosure of abuse bear the potential to exacerbate the survivor's emotional injuries (Seng et al. 2002).

Seng et al. (2002) studied sexual abuse survivors' perspectives on maternity care and found that it is not important for maternity care providers to know exactly "who" their patient and their history are, but rather focus on the "where" of the progress of their recovery from current or past sexual abuse. Several patient types related to abuse-related posttraumatic stress and desired maternity care practices emerged from the study: 1) women who were not ready to know and recognize the effects abuse has had on their lives, 2) women who were not safe from ongoing abuse, and 3) women who have made significant progress in their recovery from trauma.

The first group of women were often unaware of the impact of their trauma and thus, not ready to disclose or work through their abuse experience. However, they wanted their maternity care providers to treat them on a "presumptive diagnosis," based simply on symptoms and signs alone without actually having to bring up the cause for their traumatic stress. They needed their care provider to be a "therapeutic mentor." Moreover, it should be assumed that certain procedures, e.g. vaginal exams, the conventional dynamics of the doctor-patient relationship, and the clinical settings in which exams take place can be triggers for women who have experienced

sexual abuse. It was highlighted that the women wanted their anxiety and stress to be empathetically and gently acknowledged by their doctor, but that it was not associated with or named as a traumatic response to sexual abuse. The women in this group also described that pregnancy was not the right time for them to address and handle their history of abuse; thus, they often suppressed any memories that occurred during their everyday lives. Consequently, dissociation was a common coping mechanism in pregnancy and labor for the affected women.

Women who did not consider themselves safe from abuse had different expectations for their care during pregnancy and childbirth. They wanted their care providers to be a “compassionate authority figure” who knew about and could respond to their experiences with sexual abuse. Nevertheless, these women simultaneously expressed hesitation and challenges in asking for the assistance they desired. Frequently mentioned barriers to speak openly about the abuse were the fear of stereotypes and stigma by the care providers as well as feelings of anxiety, shame and guilt. A few women in this group did talk about current abuse and their disclosure was often met with unhelpful, shaming and careless responses.

The third group that Seng et al. (2002) identified were women who were far along in their recovery and aware of the effects the trauma of sexual abuse had on their lives. These women were looking for a “collaborative ally”. They were capable of advocating for themselves and their trauma-related needs. Even though certain aspects of maternity care, e.g. physical examinations, were considered challenging, the women in this group actively sought to avoid potential triggers by working with informed, knowledgeable providers. Furthermore, they tried to maintain as much control as possible over their medical care and its potentially triggering aspects. The need for and maintenance of control was for many women a priority for their successful relationship with a maternity care provider. Seng et al. (2002) conclude that it is

important for care staff to know how a woman might be affected by a history of sexual abuse, especially if she is triggered and cannot voice concerns and fears. This awareness can be essential for an effective response to a posttraumatic reaction and mitigate, rather than exacerbate, its consequences. Even though the women in this group had made great progress in their recovery, pregnancy was often perceived as a period in their lives for further posttraumatic growth as the physical and emotional changes of childbearing and the impending arrival of a newborn made them aware of unhealthy trauma-related behaviors (Montgomery 2013; Seng et al. 2002).

3.1 PREGNANCY AND BIRTH

Pregnancy, labor, delivery and the transition to motherhood are significant events that cause profound emotional, social, and physical changes in a woman's life (Stephens 2004). Hence, labor and delivery should be focused on the women's experiences, perceptions and satisfaction (Stewart 2004). However, many studies use quantitative data, e.g. mortality rates, to analyze maternity services whereas qualitative research that captures and includes women's voices is often deemed as rather insignificant. This paradigm can be seen in the U.S. medical maternity care system, which is heavily doctor-oriented and focuses on fetal and infant well-being and often neglects women-centered care (Wagner 2006).

A recent attempt to better understand U.S. women's experiences of pregnancy, childbirth and the postpartum period is the Listening to Mother Surveys by DeClerq et al. (2010), which are regularly conducted large-scale survey studies that gather comprehensive data about the childbearing experiences of U.S. women. Some other qualitative research has focused on the

health care experiences of survivors of sexual abuse. A study by Schachter et al. (2004) interviewed 27 female survivors of childhood sexual abuse about their experiences with physical therapists and other health care providers. A main focus was on the women's opinion of how care techniques and practices can be sensitive to their specific needs as survivor. Even though experiences regarding maternity care were not discussed, the study's results and conclusions are applicable to a broad variety of health care settings as they focus on the survivors' needs and expectations of medical care providers. Survivors wanted their care providers to act as collaborating, sensitive and equal partners who are knowledgeable and informed about the long-term effects that the trauma of childhood sexual abuse has on emotional and physical health outcomes and behaviors (Schachter et al. 2004).

Similar to Schachter et al. (2004), Havig's (2008) systematic review analyzed existing literature relevant to the experiences of childhood sexual abuse survivors in the health care setting, but does not address maternity and gynecological care. The impact of childhood sexual abuse on health behaviors and health care seeking as well as recommendations for medical staff to practice non-threatening and non-triggering care are highlighted in this research (Havig 2008). Coles and Jones (2008) also emphasize the need for care providers to follow "universal precautions" as they analyzed the complexities of physical examinations of pregnant survivors of childhood sexual abuse, especially a few weeks immediately before and after the birth.

Overall, qualitative studies examining the maternity care and birth experiences of survivors of sexual abuse are scarce. A meta-synthesis of literature on maternity care needs of women who have a history of childhood sexual abuse conducted by Montgomery (2013) identified only eight qualitative research studies published between 1994 and 2011. Except for two studies, the sample size for each was fewer than 20 women. Dominant themes recurring in

the meta-synthesis' qualitative studies of maternity care needs were identified. These are remembering, control, dissociation, and healing, with control being the strongest theme (Montgomery 2013).

3.1.1 Remembering

Procedures done as part of routine medical maternity care can be troubling for survivors of sexual assault and cause memories of the abuse to resurface. These are referred to as triggers and flashbacks. Any feelings, words or experiences that create an association between labor and delivery and the history of abuse are considered triggers. A flashback is when the survivor feels transported back to the abusive situation. Both triggers and flashbacks are often accompanied by severe fear and anxiety, especially when the survivor cannot pinpoint the cause. During labor, a lot of triggers are physical (Coles & Jones 2009, Garrett 2011) and cause feelings of being invaded, distress and helplessness.

Intrinsic triggers are connected to the rather uncontrollable processes of childbirth, e.g. nausea, vomiting, painful contractions, and bodily excretions (Simkin & Klaus 2004). The pelvic pain as well as the feeling of the baby in the vagina can trigger trauma memories (Coles & Jones 2009; Palmer 2004; Parratt 1994). Labor positions such as being on hands or knees, or having the legs pulled apart can also act as significant reminders of the abuse (Simkin & Klaus 2004). Some survivors are uncomfortable with the immediate skin-to-skin contact with their newborn. A woman participating in a study by LoGiudice and Beck (2016) described that the direct skin-to-skin contact with her baby still covered in vernix caseosa (the waxy, white substance covering the newborn's skin) prompted flashbacks of her abuser ejaculating on her chest. Elfgen et al. (2017) identified breastfeeding as a potential trigger for memories of childhood sexual abuse. For

the majority of women in Elfgen et al.'s research (2017), the flashbacks and memories of the past abuse experiences had a negative effect on breastfeeding.

On the other hand, triggers that are not directly caused by the childbirth process are referred to as extrinsic triggers and include clinical procedures, the hospital environment and its distinct smells and sounds as well as the maternity care staff. Feelings of discomfort, anxiety, fear and danger are often experienced due to the lack of privacy and respect for the survivor's body and modesty during labor (interpersonal triggers). The discomfort of vaginal and cervical exams is often associated with the genital pains caused by past abuse. Other care-related triggers include being hooked up to medical equipment and being surrounded by a plethora of uniformed strangers, i.e. nurses, anesthesiologists, and obstetricians (Simkin & Klaus 2004).

Research has also shown that phrases commonly used by maternity care staff intended to soothe and support can have triggering effects on laboring women who have a history of sexual abuse (LoGiudice & Beck 2016). Simple comments such as "Lie still and it will be over sooner," "open your legs," "relax," and "this will only hurt a little" are meant to help the survivor; however, they are often similar to wording their abuser used and thus, can cause flashbacks to abusive situations. Furthermore, common birth affirmations like "Listen to what your body tells you to do" or "trust your body" can be ineffective and meaningless for survivors of sexual violence who have dissociated from their body due to their abuse and feel betrayed, shameful and conflicted about their body and its intuitions (LoGiudice & Beck 2016; Simkin & Klaus 2004).

Triggers are an often unpredictable response to trauma, and their potentially negative effects on labor and delivery are evident. However, survivors do not need to be able to consciously recall their abuse in order to be impacted by triggers. Even though memories of the

traumatizing events might be suppressed, the body and psyche keep score and remember the emotional and physical injuries inflicted by sexual abuse (Herman 1997; Van der Kolk 2014).

In order to improve patient experience and satisfaction, researchers have called for individualized, trusting, and women-centered care during childbirth which can mitigate or even prevent the adverse effects of triggers and flashbacks (Burian 1995; Parratt 1994).

3.1.2 Control

Studies have also shown a strong correlation between the perception of maintaining control during labor and satisfaction with the childbirth experiences (Heritage 1998; Kitzinger 1992). A lack of feeling of control can also compromise treatment adherence (Schachter et al. 2004).

In all eight studies of the meta-synthesis, the loss of control is described as a strong trigger for survivors of sexual abuse that can cause re-traumatization. For some women, pregnancy and labor themselves alter their notion of being in control of their bodies, making them feel “invaded” by the unborn child (Garrett 2011). Studies have also shown a strong correlation between the perception of maintaining control during labor and satisfaction with the childbirth experiences (Heritage 1998; Kitzinger 1992). A lack of feeling of control can also compromise treatment adherence (Schachter et al. 2004).

Control during labor and delivery can be categorized in three ways: 1) self-control over reactions and responses to labor pains and procedures, 2) the survivor’s control over her own body, and 3) control over what is being done to the survivor by medical care staff. The last can be a high priority for some women as sexual abuse is often associated with inferiority and helplessness (Simkin & Klaus 2004).

Loss of control can often cause anxiety as well as hyperawareness (Burian 1995). Therefore, maintaining some control over what is done during the highly vulnerable experience of childbirth is crucial in avoiding triggers and potential re-traumatization (Simkin & Klaus 2004). Setting boundaries with maternity care providers is often a survivor's mechanism to claim authority and control (Palmer 2004). Rhodes and Hutchinson (1994) identified "taking control" as one of four labor styles (fighting, taking control, surrendering, and retreating) often observed in women who have a history of childhood sexual abuse. Control during pregnancy, labor and delivery can be gained and maintained by seeking privacy, preparing a thorough birth plan, and avoiding situations and environments where a loss of control is possible, e.g. medicated birth, pain reliever (epidural), and hospital settings. Rituals and mantras are also often mechanisms to retain control (Simkin & Klaus 2004).

In addition, as Burian (1995) highlighted, losing control is a significantly different notion compared to giving up control, and medical care staff should be aware of these different dynamics. Overall, trusting relationships with care providers are crucial to a survivor's notion of acceptance, agency, and safety. Especially during invasive procedures, e.g. vaginal or cervical exams, the feeling of being safe and in control is important for many women. Consequently, the loss of control can have more potential for trauma, anxiety, and distress than the procedure itself.

Some women respond to their fears of losing control and being left powerless by becoming hostile and defensive towards their maternity care team. Unfortunately, many care providers react to this behavior impatiently and consider their patient to be unreasonable and difficult, which often has a downward spiraling effect (Garratt 2002; Rouf 1999). Ideally, the care staff would respond sensitively and empathetically to the woman and try to recognize the

actual motives for her behavior, rather than considering her to simply have a hostile personality (Simkin & Klaus 2004).

Labor and delivery inhibit the survivors' conscious control over their own bodies. Many survivors are reminded of the helplessness they experienced during their abuse and its trauma. There is no one way to cope with this distress; however, studies have observed that women often fight their feelings of powerlessness or dissociate and withdraw from the situation. Both these coping mechanisms may subconsciously stall the progress of childbirth as fear can cause the release of hormones that halt labor (Simkin & Klaus 2004). This prevention of progress may result in the use of further unwanted medical procedures and interventions, e.g. medication, vacuum and forceps delivery, or cesarean section. This can result in a domino effect that causes further emotional or physical trauma and injury of the survivor.

Self-control over reactions and responses to labor pains and procedures concerns not only survivors of sexual abuse, but all women. As birth is consistently depicted as a horrifying, painful and bloody event, many women are anxious about making a fool of themselves and behaving in an embarrassing manner by screaming, whimpering or growling to cope with the pain. As previously mentioned, when labor progresses to the point when it is difficult to remain in control due to the intensity of pain, the fear of pain behaviors, losing control and being helpless can cause women to subconsciously keep the labor process at a level where she is in control (Simkin & Klaus 2004).

Medicated pain relief in the form of an epidural often allows women to have greater control over their responses to labor pains. On the other hand, an epidural limits mobility and control of the legs which can be anxiety-inducing for women who prefer to feel that they could physically escape or protect themselves by being mobile and able to walk (Simkin & Klaus

2004). Additionally, the administration of an epidural itself can be triggering since the anesthesia is typically done by an unknown, unseen person at the back of the survivor which may be reminiscent of childhood sexual abuse from behind.

3.1.3 Dissociation

For survivors of sexual abuse, dissociation is a common protective coping mechanism to keep oneself separated and safe from stressful, traumatic events and its pain. It can act as an escape from labor pains which are often experienced as more physically intense for women with a history of sexual abuse (Clarke 1998). It is also a primary response to the loss of control (Coles & Jones 2009; Garrett 2011; Palmer 2004; Seng et al. 2002).

A woman who is dissociated from her body during pregnancy and childbirth might be unable to recognize first signs of complications, e.g. premature contractions, infections, minimal fetal movement or even early pregnancy itself (Seng & Hassinger 1998; Heritage 1998). Often learned in childhood, dissociation is mainly used in situations that are emotionally or physically similar to the experienced abuse (Garrett 2011). There is no universal form of dissociation as it shows in different forms, e.g. loss of eye contact, becoming unresponsive or being paralyzed (Coles & Jones 2009).

For Rhodes and Hutchinson (1994) dissociation can be either surrendering or retreating labor styles reacting to the challenges and triggers of childbirth. Thus, on the one hand it is believed that women in childbirth will potentially require help to stay focused and present at the birth in order for labor to progress. On the other hand, dissociation is perceived as an important coping strategy for women who are too triggered and fearful to stay in the present childbirth environment (Palmer 2004).

3.1.4 Healing

Pregnancy and childbirth can signify a new beginning for some women who have been sexually abused. Unhealthy behaviors influenced by the experienced trauma can be acknowledged and changed. Many survivors of sexual abuse have a complex, and often poor relationship with their body and feel it has failed them (Simkin & Klaus 2004). Lasiuk (2007) showed in her research, however, that a positive, safer birth experience can alter such a relationship and have a healing influence.

Feeling safer requires a birthing environment in which the laboring woman is in control and not reminded of her abuse (Montgomery 2013; Schachter et al. 2004). Being treated in an accepting, empathetic environment where the laboring woman is considered and approached by her care provider as an equal team member facilitates the healing effects (Schachter et al. 2004). Forming a trusting relationship with her maternity care team can benefit a survivor's feelings of agency, self-efficacy, and competence as well as improve her pregnancy and childbirth experiences. Consequently, a satisfying and successful birth experience is a powerful milestone that can make a sexual abuse survivor feel accomplished. It can also positively affect the relationship she has with her body, as it shows to her that she is physically and emotionally strong and in control (Lasiuk 2007; Palmer 2004).

3.2 BENEFITS OF DOULA CARE

During the twentieth century, birth increasingly moved away from the private sphere to clinical environments. Today the majority of women no longer give birth at home, but rather in a hospital. Consequently, childbirth has become a highly conforming, medicalized, managed, and sterile procedure and event (Kitzinger 2012; Wagner 2006). A result of this shift of paradigm is the high rate of cesarean sections which has increased by more than 50% from 1995 (Martin et al. 2013; Wagner 2006). Approximately one-third of births are now by surgical delivery, although research has highlighted that this significant increase has contributed to complications, rather than improve birth outcomes (Goer & Romano 2012; Weiss, Elixhauser & Andrews 2014).

When giving birth in a hospital, laboring women are often subjected to clinical routines, interventions, frequent exams, limited privacy and unfamiliar hospital staff. The dynamics of the doctor-patient relationship and hierarchy can also reduce a woman's individual agency, especially as she is faced with the stress, vulnerability and unpredictability of childbirth (Wagner 2006). These and other conditions can be experienced as disempowering and hostile and thus, potentially hinder the progress of labor. Furthermore, it is argued that negative or conflicted feelings about the childbirth experience can often remain with the mother during the postpartum period, and may increase the risk of postpartum depression and impair mother-infant bonding as well as breastfeeding initiation and success (Bohren, Hofmeyr, Sakala, Fukuzawa & Cuthbert 2017).

Historically, however, birth was not a medical procedure, but rather considered a female rite of passage and approached more holistically (Kitzinger 2012). Women used to attend to and support one another during labor and childbirth, making birth "women's business" (Kitzinger 2012, p. 301). The scope of continuous one-on-one labor support, as provided by a labor doula

entails nonmedical emotional assistance (such as reassurance), information about the different stages of labor and childbirth, coping techniques and physical comfort measures (e.g. massages, mobility, warm showers) and advocacy before, during and immediately after childbirth. A doula provides individualized care that empowers women to make informed choices, give informed consent and voice their birth preferences, concerns, and values to maternity care providers (Strauss, Giessler & McAllister 2015). Doulas are not considered medical professionals and thus, do not provide medical services or consultations, but work alongside clinical maternity care staff.

An explanation for the positive effects of continuous labor doula support on birth outcomes is that this form of women-centered care can strengthen feelings of control and engagement in care decisions in the laboring mother, which consequently makes the utilization of medical interventions less likely. Continuous companionship can buffer and mitigate the stressors of clinical birth environments (Breedlove 2005; Gruber et al. 2013; Hofmeyr, Nikodem, Wolam, Chalmers & Kramer 1991).

Unrelated to the birthing environment, labor doula care primarily applies individualized and evidence-based techniques to alleviate the emotional and physical challenges of labor and delivery (Hodnett 2002). Women are encouraged to be mobile and walk around and to make use of gravity and various laboring positions, e.g. squatting or being on hands and knees. Research studying stress responses and pregnancy complications has shown that anxiety during labor releases an increased amount of the stress hormone epinephrine which can cause longer active labor, an abnormal fetal heartbeat and decrease the intensity and effectiveness of contractions (Lederman 1981; Wagner 2006). Moreover, medical interventions, e.g. induction of labor and epidural anesthesia, may lead to a cascade of interventions that can alter birth progress and affect the woman and her newborn adversely, both in the short and long term (Buckley 2015). The

emotional, physical, practical, and informational support provided by a labor doula can decrease the risk of this cascade mitigate anxieties and fear related to childbirth. Consequently, birth experiences can be improved (Anim-Somuah 2011; Caton 2002).

Even though the different types of labor support and their benefits have been widely acknowledged, the recent shift in the paradigm caused doula care to become a scarcity as only about six percent of births in the United States are attended by a support person who continuously and solely focuses on the emotional and physical needs of the childbearing woman (Chapple et al. 2013; Gilliland 2010; Hofmeyer et al. 1991; Jordan 2013).

Despite significant technological and infrastructural advance and extensive financial spending, the maternity care system seems to be failing to meet the needs of mothers and their infants, as the U.S. is one of the few countries in the world where maternal mortality is rising.

Moreover, racial disparities in medical maternity care are evident. The complex challenges and stressors that women of color face in the U.S. affect their likelihood of achieving positive birth outcomes (Hogan, Shanahan & Rowley 2011). The pregnancy-related mortality ratio in 2011-2013 was 43.5 deaths per 100,000 live births for African American mothers, compared to only 12.7 deaths per 100,000 live births for white women (Creanga, Syverson, Seed & Callaghan 2017). No matter the income level, African American women experience about a threefold risk of maternal mortality compared to similarly situated Caucasian women (Singh 2010). These health disparities cannot solely be explained by socio-economic status, but are rather independently affected by race (Kozhimannil, Vogelsang, Hardeman & Prasad 2016).

The nation's relatively high rates of maternal deaths and complications, and the significant racial disparities in maternal health care as well as the excessive spending and costs of childbirth care signify an urgent need for fundamental, institutional changes of the maternity

care sector. Concerns about the lack of respectful women-centered and evidence-based care in the U.S. maternity care system have led to a growing body of research that emphasizes the significance of continuous, one-on-one support by women for women to improve birth outcomes, increase maternal satisfaction and decrease spending on unnecessary medical interventions (Declercq et al. 2007; Gilliland 2002; Gruber et al. 2013; Kabakian-Khasholian et al. 2015; Wagner 2006).

Doula services also align with the “triple aim” of the Affordable Care Act which calls for care to better the patient experience, and improve health outcomes and health disparities, as well as reduce the cost of treatment and services (Patient Protection and Affordable Care Act 2010; Strauss, Giessler & McAllister 2015).

A Cochrane Review on continuous support for women during childbirth identified 26 studies from a total of 17 countries. All included studies showed that continuous support in labor can improve a wide number of outcomes for the mother and her newborn alike. No adverse outcomes have been reported. The review concludes that “continuous support from a person who is present solely to provide support, is not a member of the woman’s own network, is experienced in providing labor support, and has at least a modest amount of training (such as a doula), appears beneficial” (Bohren, Hofmeyr, Sakala, Fukuzawa & Cuthbert 2017, p.3.)

The joint publication ‘Safe Prevention of the Primary Cesarean Delivery’ (2016) of the ACOG and the Society for Maternal-Fetal Medicine states that “one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula” (p.13) as it is “associated with improved patient satisfaction and a statistically significant reduction in the rate of cesarean delivery” (p.13). The publication also acknowledges that doulas are “probably underutilized” (p.13). Similarly, in two of its recent guidelines, the World Health

Organization (WHO) recommends continuous support during labor and childbirth as a tool to improve labor outcomes and maternal satisfaction with care services (WHO 2015; WHO 2016). Research credits continuous support with positive effects on physical labor outcomes, mental well-being, and economic benefits.

3.2.1 Effects on physical labor outcomes

Women who have continuous labor support as provided by a doula have a 31% decrease in the use of synthetic hormones, such as Pitocin, used to induce or speed up labor (Gruber et al. 2013). Births supported by a doula are quicker, less likely to be medicated and less likely to require a cesarean section (Campbell et al. 2006; McGrath & Kennell 2008). Moreover, the likelihood for a woman to initiate breastfeeding is about 25% greater compared to women who did not have a doula attend the birth (Campbell et al. 2006; Gruber et al 2013; Wagner 2006). Infants born to women who had continuous labor support show a higher immediate APGAR¹ score and are thus 14% less likely to be admitted to a Neonatal Intensive Care Unit (Campbell et al. 2006; Hodnett 2002).

3.2.2 Effects on mental well-being

Childbirth is a significant event for many women, and the emotions associated with this experience can be crucial for maternal and infant physical and mental well-being as well as for mother-infant bonding (Wagner 2006). Research has shown that the continuous support,

¹ Common method to quickly evaluate the health of a newborn. Categories are: **A**ppearance, **P**ulse, **G**rimace, **A**ctivity, **R**espiration <http://www.nlm.nih.gov/medlineplus/ency/article/003402.htm>

encouragement and reassurance provided by a labor doula increases maternal satisfaction, self-esteem, and confidence about themselves and their birth experiences (Gruber, Cuptio & Dobson 2013). The undivided attention a doula offers a laboring mother enables a trusting relationship that can facilitate discussions about any fears, worries and concerns regarding the birth. The individualized, thorough and unbiased care and support can be empowering to the mother and help her make informed choices and maintain positive communication with her medical care providers. Having a sense of control and agency over decisions regarding health care can improve overall satisfaction with the birth experience and obviate birth trauma (Cook & Loomis 2012; Hardin & Buckner 2004).

3.2.3 Economic benefits

Childbirth in the United States is expensive. Cumulative costs are approximately at \$60 billion per year which exceed those charged for any other form of hospital care (Childbirth Connection 2012). Overall, the expenditures on maternity and childbirth care of the U.S. are higher compared to any other country (International Federation of Health Plans, 2012). In order to increase the cost-effectiveness of the domestic maternity care system, the excessive use of main contributors of childbirth-related expenses, e.g. medical labor interventions and cesarean sections, needs to be decreased. Doula care can help achieve this endeavor, as research has shown the decreased utilization of medical interventions caused by continuous labor attendance and support.

Few studies have examined the economic and financial benefits of doula care in the United States (Chapple, Gilliland, Li, Shier & Wright 2013; Tilman, Gilmer & Foster 2012). Considering the positive physical and emotional effects of labor doula care, research suggests the

need for insurance coverage for doula services. A reduction of excessive spending on non-beneficial procedures, interventions, and complications could contribute to the financial coverage and reimbursement for doula services, which consequently can significantly increase access to and utilization of labor doula services. This is expected to make positive birth outcomes associated with doula care more prevalent.

Cesarean sections are about 50% more expensive than vaginal births (Wagner 2006). Research has highlighted an average 28% decrease of cesarean sections in women who received continuous labor support, thus, expenditures on surgical delivery could be reduced by approximately \$43 million for Medicaid births and \$41 million for private insurances each year (Strauss et al. 2014). As rates for vaginal birth after a previous cesarean section are low, most subsequent births that follow a cesarean section are repeat sections. Obviating a primary cesarean section can therefore reduce the costs of future pregnancies and birth (Liu et al. 2007).

Furthermore, women who receive doula care during labor are less likely to request pain analgesia. Epidural anesthesia in particular is a costly intervention that includes fees for the anesthesiologist, medication, and the increased risk for further interventions such as bladder catheterization, medication to progress labor, or episiotomy (Romano & Lothian 2008).

Doula care has also shown to significantly increase a woman's likelihood to initiate breastfeeding and delay formula feeding (Gruber, Cupito & Dobson 2013; Mottl-Santiago et al. 2007; Newton et al 2013). Research suggests that if national breastfeeding goals were reached, \$31 billion could be saved, as breastfeeding is proven to improve maternal and newborn short- and long-term health (Bartick & Reinhold 2010; Bartick et al. 2013). Consequently, doulas can have an influential role in individual, communal and federal cost-savings (Chapple, Gilliland, Li, Shier & Wright 2013; Kozhimannil, Hardeman, Attanasio, Blauer-Peterson & O'Brien 2013).

3.3 DOULA CARE AND SURVIVORS OF SEXUAL VIOLENCE

A positive and trusting relationship with a maternity care professional can be a powerful tool and beneficial experience for a survivor of sexual violence. Many of the survivor's childbirth needs can be met by the overall scope of labor doula care. Doulas are trained to create a safer, non-judgmental space for women to discuss their concerns, fears and thoughts about the impending birth, regardless of a disclosure of their experienced trauma. The expertise and insight of a doula allows for individualized discussion and information about interventions and exams that can occur during the medical care of pregnancy and childbirth.

In order to avoid triggers, flashbacks and re-traumatization during a pelvic exam, for example, a doula can talk the woman through the procedure and reassure her of her safety and control. This notion of self-efficacy and agency is essential to doula care, as it views women to be an expert of their own bodies and active participants in informed choice. Doula care is women-centered with no specific agenda other than supporting the achievement of a woman's individual desired birth experiences.

4.0 RESEARCH QUESTION

The aim of this research study is to examine labor doula care as a non-medical form of support for childbearing survivors of sexual violence who may experience triggers and re-traumatization during labor and delivery. The research question asks how labor doulas and their scope of practice can assist women who have experienced past sexual violence to cope with trauma-related barriers and challenges during childbirth?

4.1 METHODS

This study explores continuous support provided by labor doulas and how they can assist sexual violence survivors in coping with trauma-related challenges during childbirth. To achieve such goal, a small sample of labor doulas was interviewed and asked open-ended questions about experiences working with affected women during pregnancy and childbirth. The findings contribute to literature examining alternative forms of support in maternity care for survivors and to a better understanding of the benefits of doula care for vulnerable target populations.

A literature review was conducted to learn about trauma-related obstetric challenges of survivors of sexual violence. This helped create the interview guide utilized for face-to-face informant interviews with labor doulas to understand the scope of their services and how these can support survivors of sexual violence during childbirth. The open-ended questions focused on

the doulas' training and length of practice, their experiences in working with survivors of sexual violence, support and coping techniques, triggers during childbirth, screening for and disclosure of a history of sexual trauma, and survivor empowerment during childbirth.

Components (Agency, Personal Security, Connectedness, Respect, and Knowledge) of the *Good Birth* model by Lyrly (2013) were used to conceptualize how the childbirth experiences of survivors of sexual violence may be affected by labor doula support and the maternity medical care team. The majority of data collected in this study related to the doula's actions, perceptions, and interactions and this paper presents themes relating to these results.

4.1.1 Study participants and recruitment

A labor doula who worked for a local community-based doula program sent out an initial recruitment email directly to peers. Other forms of recruitment included word of mouth and social media. Inclusion criteria included general work experience as a labor doula and fluency in English. As disclosure rates about experiences of sexual violence are low, labor doulas who suspected potential abuse trauma in clients even though it was not disclosed to or discussed with them were eligible to participate in the study. Three labor doulas who practice in Pittsburgh and its metropolitan area were interviewed in October 2017 at a public location of their choice. All interviews were between 45 minutes to 90 minutes long and research participants consented to participate using the human subjects' protection process as approved by the University of Pittsburgh IRB under the number: PRO17080151.

4.1.2 Data

A semi-structured interview guide consisting of open-ended questions was developed by the author who is experienced and trained in the collection and analysis of qualitative data. The interview questions focused on the experiences the doulas had made in caring for women who they knew or suspected have had experienced sexual trauma, a doula's role in screening for a history of sexual abuse or responding to its disclosure, as well as survivors' empowerment during labor and delivery. The sample size was expected to be between five to ten doulas. As recruitment was slow and the timeframe for this research limited, a total of three labor doulas were interviewed. However, common themes regarding the experiences of doulas in caring for survivors of sexual violence were evident and recurring after the completion of these interviews.

4.1.3 Analysis

The interviews were digitally audio recorded using a smartphone application and manually transcribed verbatim. One researcher read the transcripts thoroughly and used a grounded theory approach for analysis (Ulin, Robinson & Tolley 2004). Through line-by-line coding, initial codes were created. Single, but significant comments were also recognized and highlighted. Based on these codes, a codebook was compiled.

Throughout the process of analyzing the transcribed interviews and assigning codes, it became evident that participant comments consistently aligned with the Good Birth framework as described by Lyerly (2013). Based on in-depth interviews with more than a hundred women, this framework identified the five themes of personal security, knowledge, connectedness, respect, and agency. These are essential core elements of a good birth experience that meet the

physical and emotional needs of mothers, no matter the circumstances or mode of delivery. In the context of childbirth experiences for survivors of sexual violence, Lyerly's framework also supports and explains the beneficial effects that doula care can have on vulnerable populations (Kozhimannil, Vogelsang, Hardeman & Prasad 2016). Data collection of this study was not guided by the Good Birth framework, however, because its five themes were common among participant comments, the framework was applied post-hoc. Therefore, the codebook was modified to adjust for this categorization highlighting the recurring key themes as described in the Good Birth framework.

4.2 RESULTS

All three study participants had experiences in working with women who had disclosed their history of sexual violence to them. However, the majority of experiences were made in working with women who did not disclose trauma, but showed signs of triggers related to sexual trauma during the progression of labor and delivery. Two participants worked in the same community-based doula program whereas one participant is in private practice and has founded her own birth doula agency. All participants were trained through the training organization Doulas of North American International (DONA International) about ten years ago. Two of the doulas had the same trainer.

4.2.1 Key Themes aligning with Good Birth framework

The key themes Personal Security, Knowledge, Connectedness, Respect, and Agency of the Good Birth framework were recurring in the interviews and are elaborated with illustrative quotes as described below.

4.2.1.1 Personal Security

A woman's feelings of emotional and physical safety for the environment and the people surrounding her are a significant determinant for birth experiences. Women who perceive their personal security as challenged due to the experience of past trauma may show a heightened need for comfort and safety, particularly during the vulnerable and emotionally and physically stressful event that is childbirth. Doulas can meet this need for personal security by providing various forms of reassurance. Doula A recalled working with a woman who panicked as doctors strapped her arms to the operating table in preparation for a cesarean section.

Be the voice in her ear that says, 'It is going to be okay. I know this might feel really bad right now. They are working to get your baby. And it is going to be good, okay. You are okay. You are safe. Nobody is going to hurt you here'. ...So much of it is reassurance. It really is that sense of like, 'It is going to be okay. Nothing bad is...' and 'I am right here with you' (Doula A)

Doula A also recognized that

...it is such a critical time and that is why I think for people coming back to sexual trauma, it just follows that...for them to feel so accepted in their vulnerability. It has to be a good thing...and it is so empowering because you know that the people around you are really looking out for you. I think creating more of a supportive environment for mothers

would help them. ... For all mothers, not just the ones that had sexual assault or trauma. It would benefit them too and it would benefit everybody.

Doula care has no set agenda other than assisting the mother with her individual needs to help achieve her desired birth experiences. The participant interviews showed that a significant core value of doula care is nonjudgmental, unbiased support.

I think doulas do so much for all women and as I said, I think all women have experienced some kind of sexual harassment, sexual abuse and especially when it is early childhood abuse, it comes up so much in pregnancy and birth and parenting. Just to have somebody there to... it takes a lot of energy to just be there for somebody and to suspend all judgment and suspend all plans for her. Like really empty yourself of an agenda and just be there for her. ...When doulas are there and they can create that space, I think that everybody should have a doula for that reason. And I think...doulas who are specifically there to kind of be guardians of informed consent. (Doula C)

Doula B summarized that doula care “*is about creating a safe space where a pregnant woman can say what she needs to say and ask for what she needs to ask for*”. Creating this safer space free of judgment and bias is crucial for all women. However, especially for women who have experienced sexual abuse and often feel dismissed and silenced by society’s constant stigmatization of survivor experiences, this safer space can be a powerful tool in comprehensively discussing trauma-related concerns and worries regarding pregnancy and childbirth.

It has been discussed that survivors of sexual assault may show an increased need for maintaining control during childbirth in order to feel satisfied with the birth experience. However, if personal security feels threatened, it is likely that the fixation on control and safety

heightens and hence, inhibits a surrender to the unpredictability of the birthing process. All three participants talked about instances where medical care staff disregarded a woman's personal security and reacted impatiently and dismissively when the woman was not compliant or reacted emotionally. The doctor-patient power dynamics of the clinical environment as well as the doctor-patient hierarchy were mentioned frequently throughout the interviews to affect a woman's sense of safety. In order to recalibrate the relationship dynamics and enhance feelings of personal security, Doula C suggested that *"having a framework where somebody is fully clothed and you are both at eye-level sitting, looking at each other and asking, 'Is it okay if I do this?' is a real game changer"*.

4.2.1.2 Knowledge

Similar to the existing body of research, the participant statements of this study have shown that doulas are a significant source of individualized knowledge about the emotional and physical challenges of childbirth. This transfer of knowledge and information can be empowering to the childbearing woman and help her better prepare her labor and delivery. All participants stated that they avoid a direct inquiry about a potential history of sexual abuse as a gateway to talk about the effects trauma can have on childbirth.

I do have a section in there that says, the following situations may affect your birth. And one of the things that I have on there is that if you are a survivor of sexual abuse or assault, because it can affect the trajectory of your labor. So, I have it on there. I don't ask them if they are. But I have it on there along with some other things, like 'Did you have any procedures done to your cervix?', those types of things. So, I have it on there so that, because they may not even realize that it could affect their birth. ...You have to give

them the opportunity to actually think about whether or not it is going to affect them.
(Doula B)

I feel like planting the seed of you know, we are aware that this is a super common thing. Please feel like you can talk to us about it, but not putting them on the spot about it.
(Doula B)

Doula C recounted working with a woman who experienced pregnancy difficulties and needed blood work, a triggering procedure that caused her to hyperventilate and feel scared.

And nobody had taken the time to explain to her what the syndrome was that we thought she had. So, when I showed her, I had printed out information and showed her the only way we can get information unfortunately that is definite is from blood work. And I told her that I am so sorry and wish that there was, but there isn't really another way or information that we can get to know what the next step is going to be. And she was like, "Oh, I totally understand now. I want my blood drawn. I just need like 20 minutes to get ready".

Interview comments also showed that doulas can play a significant role in connecting survivors of sexual trauma with resources and referrals in order for them to improve health outcomes and comprehensively prepare for childbirth and the postpartum period.

If she is somebody who has not had counseling, I am going to go and get her some resources. ...I would obviously try to get her some referral and some resources for places she can go. (Doula B)

4.2.1.3 Connectedness

The level of connection to resources available to a childbearing survivor of sexual violence can improve the birth experience and maternal satisfaction. Resources can be her medical maternity care team, local services, and trusting people in her life, as well as her doula.

Women take in so much of how they are treated. We were always making the case that for a lot of women it is the first interaction with the healthcare system as an adult [...]. And so, they take in and internalize either those feelings of shame, that feeling of not being listened to or being out of control versus the feelings of ‘Oh, there are my partners who are making sure that I am safe and that my baby is safe’. And I think that is really important too. (Doula C)

An established connection and trust between the doula and a survivor of sexual abuse seemed to mitigate some stressors of childbirth and minimized feelings of isolation. The individualized emotional support is a significant component of doula care, as highlighted in the participant statements.

Most of the doula work I think is time. It is not technology, it is not any specific technique. It is just being. ...It is so simple, but nobody does it, except for doulas. I really just sat in the dark with her. It was a night shift. I did not say anything for like ten minutes and just showed her that I was not going to make any sudden movements and then she said that it is okay. (Doula C)

But I do think it has always been useful, at least in my experience, having sort of that additional person of the doula who isn't as emotionally caught up in the birth like both the parents are and isn't a provider that has medical responsibilities but who can really try to see what she needs and make sure that she gets that reassurance. I think it is a

lot...I mean, ninety percent of it, I don't know, it is...so much of it is reassurance. It really is that sense of like 'It is going to be okay', 'Nothing bad is...'” and 'I am here with you'. That's what I remember saying a lot – 'I am right here with you. We are both here with you'. (Doula A)

Just making sure that I am completely available to them at all times. Getting there as early as I possibly can because I know if they have disclosed to me, I know they are going to need somebody to hold their hand probably during the exams and such. (Doula B)

4.2.1.4 Respect

Respectful treatment is an essential component of women-centered maternity care that enhances the birth experience and maternal satisfaction. Research has shown that feeling in control and being met with dignity, empathy and respect is more likely to make a woman feel satisfied about the birth than the physical and clinical features of the delivery process (Simkin 1991). Acknowledging a woman's autonomy and competence in labor engages her to make informed decisions. When asked what they think would help survivors of sexual abuse feel empowered during labor and childbirth, the theme of respect was recurring among all participant answers. The trauma of sexual violence can impact a survivor's notion of respect. Consequently, an experience where a survivor's voice and authority is respected can be empowering, as emphasized in the stories shared by the study participants.

So, to come in and be like 'Let me put this thermometer in your mouth' or 'I need you to sign this'. Like have some respect for what she is doing because she is focusing. You are focusing whether you want to or not even if you are just sitting there and tensing up. You are doing your best with it. So, I think having people around you that you can trust and that are going to be like 'Hold on, she is having a contraction'. And that is great...and it is so empowering because you know that the people around you are really looking out for

you. I think creating more of a supportive environment for mothers would help them... for all mothers, not just the ones that had sexual assault or trauma. It would benefit them too and it would benefit everybody. (Doula A)

...the idea of having people around you who listen to what you say you want done with your body. I am saying that we need to hold up here and people are listening to me. People are respecting my wishes about my body. ...That really made a difference for her. (Doula B)

I think having an opportunity to intentionally talk and then about the idea that it is your body. It really is your body. And nobody's here to do anything to you that you don't want to do with your body. And you are the expert of your body and the expert on your experiences. And, I am here to remind you of that. ...And you are the one who gets to be in control of your body. (Doula A)

4.2.1.5 Agency

The ability of a woman to be in control and make informed choices regarding her medical treatment is defined as agency. Through direct questions and prompts, the participants help expectant women find their voice and express individual needs, concerns, and fears about pregnancy and the childbirth process. The participants shared experiences which show that doulas play a significant role in encouraging a notion of agency, competence and self-efficacy in their clients.

Advocacy happens outside of the birth room. You advocate, you help her find her voice, but you don't step in and speak for her. (Doula B)

But I think just creating that safe space where people, mothers, can talk about what they are afraid of and what they know about themselves. They know the most about themselves. And so, and I think that is one of the things that we are always trying to say,

'You are the expert of your body. You are going to have a lot of medical practitioners but you are the expert'. It is your body and so, any clues that you want to give me or that you want to pass on to your providers is just better. (Doula A)

Let people know that they have the right to choose their own provider if they don't like their provider. I also work in triage a lot as a nurse and people come in and they don't ever know their names of their doctors and they have seen a different doctor every single time. So, they stop coming to appointments and then they get labelled as non-compliant and they get treated badly and it is just this vicious, vicious cycle. And none of it makes sense. And none of it is intended by design for good care. So, I think doulas make a huge difference in establishing the relationships and really being a mechanism for better informed consent. (Doula C)

I think it is important that they can ask for something and have that thing respected or even celebrated, that it is not like a bizarre request. You know, people asking to wear their own clothes, I think that there are just things that we see as not being medically consequential but they are deeply emotionally and socially consequential for people and it matters....Maybe it is really important to her to get to walk or take a shower now and maybe that has really deep meaning if there was something with abuse or feeling fluids on your body. ...So, when it doesn't seem like it has an obvious consequence to you, but it is important to her, just believe it and do it. I think that can be a really a thing that matters and a thing that makes her feel like 'Okay, this is mine. This is my time!'
(Doula C)

4.3 DISCLOSURE

Applied to the maternity care needs of many sexual abuse survivors, this study extends the characteristics of the Good Birth framework as it explores the topic of disclosure of a history of sexual abuse as an additional element that may impact a survivor's satisfaction with the maternity care and childbirth experience. Disclosure can be a powerful and empowering experience for sexual violence survivors that can trickle down and thus, affect the five original key elements of the Good Birth framework as disclosure often precedes labor and delivery.

Disclosure was a highly discussed and recurring theme throughout the interviews as all participants have some experience in working with women who have disclosed to them their experiences of sexual violence. However, considering the statistics of sexual violence as well as the complexities of disclosure, the participants pointed out that they have assisted numerous women where they could only suspect a history of sexual violence. These women did not disclose, but experienced trauma-related triggers and distress during childbirth and labor. The interviews also highlighted that women who did disclose their history of sexual violence to their obstetrician and nurses were often met with more sensitivity, patience and empathy and were treated more gently compared to women who had not disclosed but showed signs and triggers during labor and childbirth related to sexual abuse trauma. However, all participants highlighted that due its high prevalence, the assumption should always be that you are working with a survivor of sexual violence, even if there was no disclosure. Even though disclosure is not essential or needs to be detailed in order for a doula to provide sensitive and adequate care, the participants emphasized that the way they inquire about a history of sexual violence is highly crucial.

I feel like we should ask in a more open-ended way about what people need. And if there is anything they want to tell us, including about experiences, I really truly feel that the people who are going to disclose are the ones who already feel a little bit safe. And the very people we want to better serve are the people that will say no. ...I don't like that we ask a yes-or-no question because we are actually putting people in a position where they have to lie out of self-preservation or disclose something when they are backed in a corner. I think there is always a reason for a doula to say, "Is there anything that you would like me to know that will help me do a better job with being your advocate or being with you?" (Doula B)

Women are grilled all the time with questions that they feel forced to answer or sometimes they are forced to answer because they want to get XYZ service. So, doulas are service providers and if people feel like their service is contingent on answering private, personal questions...I just think it should be open-ended. (Doula C)

I am not going to be like "Oh, do you have a previous history of sexual trauma?". ...I would say "Can you talk a little about your relationship with your body? Are there things that you are uncomfortable with and think they are important for me to know?" and that is such a general question. And sometimes people will say "I am fine" but then we talk some more and I am trying to give the mom examples like, some people don't like to be touched a certain way or some people are really uncomfortable with certain things. Once they know what other people have said, it's "Oh, I don't want to be looked at" or "I don't like strangers coming in". (Doula A)

Doula A recounted a client disclosing her history of sexual abuse to her obstetric provider.

The provider was just sort of like "Waaa, not my realm. Let's get you a social worker!" I remember talking with one provider and he was like "I have this much time. Why should I go into things that I am not going to be able to solve or do anything about?!" So, I get that point of view but I think that is a little but reductionist not to recognize that that's going to come up. If you don't have time to talk about it now, it is going to come up sooner or later. So, why not?!...I feel like they could and maybe some do. But I do think

there is the idea...of having some sort of tools in their toolbox to be able to not just check that box. "Oh, sexual trauma. I hope you are getting some help with that!". ...Again, not that they are really going to address it and spend 45 minutes to go over it with the patient but...there should be something between nothing and solving it.

4.4 CURRENT CLINICAL ENVIRONMENT

Another theme recurring during participant interviews which was not anticipated and did align with the Good Birth framework was the participant doulas' experiences of the current clinical maternity care environment and the care it often provides to childbearing women. Participant comments highlight that the needs of laboring women, unrelated to a potential of experiences with sexual violence, are often invalidated or dismissed.

It just seemed like a really uncaring system approach. I don't fault the people who did it. I mean, I think they were following their training and what they thought needed to be done but it just felt really like her needs were kind of secondary to them. It just didn't seem that there was space to recognize her potential history and how what they were doing might be affecting her because of her potential history. It was almost like there was no room to care about how she was feeling, that type of thing. (Doula A)

Doula C recounted an experience where a medical provider ignored her patient's distressing response to a pelvic exam. This participant statement also highlights how a doula can act as a buffer and mediator between provider and patient and help a woman overcome trauma-related challenges during labor and delivery, as well as regain agency.

A young woman doctor came in and was really kind of impatient with her being nervous about having a speculum exam to check the bleeding. And the patient, she went from appearing to me to be totally fine and speaking at a regular pace, to sweating through

her gown in about two minutes and like not being able to speak and crying and the doctor would not stop. And I said, "I think you need to... I think she needs a break!". And I said to her, which is one of my tricks which worked a lot really well as a doula and I kept it as a nurse and I say, "Do you need to go to the bathroom for a few minutes and we all step out?" and at that point, the doctor has two choices. She can contradict me and make it much harder or she can get mad at me and just leave the room. So, most of the times the doctors will just get mad at me as the doula or nurse and leave the room. She took out the speculum and like huffed about and while the patient was in the bathroom, the doctor said to me as the doula, she said, "She is being really immature. I think she is young, this is her first pregnancy. She doesn't know what she is talking about" (Doula C)

And I think really true, informed consent and decision making, universally which doesn't happen...I don't see a lot of providers asking consent before two big things in labor: before doing any kind of cervical check or before breaking people's waters which I think is so violent. People will just break the water and tell her after the fact. (Doula C)

She backed away from them a lot but I worked with those nurses and they are not the gentlest people in the world and they actually said to her husband, "Has your wife been raped in the past?" or something like that up in the hallway because they thought her reaction... and maybe she was, and maybe she does not want her husband to know that. Maybe it is something that she has never been able to share with him. And I thought it was very inappropriate of them to even bring it up to her husband. ...Some of those nurses are so callous...they will say things like "So, this person was raped. And how is having a baby more triggering than having sex with your own husband?!...And it horrifies me, the attitudes of some. You expect a little more compassion than that. (Doula B)

These statements show how the doula participants experienced the care some of their clients received and how it seems to be in contradiction to the key themes of the Good Birth framework.

Even though these perceptions should not be used to make generalizations, it is crucial to address the hostile disrespect and misogyny some providers treat their laboring patients with. Freedman and Kruk (2014) highlight that disrespect and abuse of women in labor and delivery is prevalent in many countries and is often caused by fractured maternity care systems failing to meet accountability and quality standards. This is not only a disservice for childbearing women, but also for their maternity care staff who often have to succumb to the systems' harsh working conditions and environments.

4.5 DISCUSSION

The goal of this study was to understand how labor doulas can assist survivors of sexual abuse avoid re-traumatization and cope with trauma-related challenges that may occur during labor and delivery. The participant statements emphasize that continuous labor support from a doula can play a significant role in assisting survivors of sexual abuse overcome trauma-related barriers to achieve improved birth outcomes, experiences, and maternal satisfaction.

Obstetricians provide direct patient care that is often primarily focused on the medical and physical complexities of pregnancy and childbirth. Even though the skillset of a labor doula is of non-medical nature, doulas can communicate with the obstetric care team and help survivors of sexual violence explore and voice their social support and maternal health needs. The individualized, women-centered emotional and physical support they provide can facilitate a sexual abuse survivor's likelihood of a good birth experience as well as their abilities to mitigate the effects of trauma-related triggers. The study participants identified doula care as a

mechanism for informed consent and choice which can impact satisfaction with the birth experience and avoidance or reduction of re-traumatization.

The findings of this study align with the five themes (Personal Security, Knowledge, Connectedness, Respect, and Agency) that emerged in Lyerly's (2013) Good Birth framework. Respect and Agency were the most recurring themes throughout all participant interviews. The infliction of sexual violence often disregards and takes away a survivor's sense of respect and agency. Thus, it is understandable that these are salient themes and components of traumatic responses and lead back to the potential healing thereof. Being treated with respect and given agency during labor and delivery can be a powerful experience for a woman whose notions of respect and agency were previously severely disrupted.

Additionally, with reference to the five key elements deemed crucial by the Good Birth framework for the achievement of a satisfying birth experience, the participant comments highlight that these themes of personal security, knowledge, connectedness, respect, and agency seem to be absent in the current status quo of the medical model of childbirth. Clinical maternity environments and obstetric care may be dismaying for all childbearing women, and potentially re-traumatizing for survivors of sexual violence as complex trauma-related barriers may be exacerbated.

It is crucial for future research efforts to capture the perspectives of survivors of sexual violence, obstetricians and other clinical maternity care staff to more thoroughly understand their experiences and how non-medical continuous labor support can help survivors overcome trauma-related stressors and challenges that are prevalent in the medical birthing environment and system.

4.5.1 Implications for Policy

This study has provided insight on how labor doulas can support survivors of sexual abuse in preventing re-traumatization and coping with trauma-related challenges that may occur during childbirth. The benefits of doula care have been well documented, however, the majority of published research on doula care has been conducted among non-diverse samples. Only a few studies have explored the effect doula care can have on the birth outcomes of vulnerable populations, e.g. low-income or incarcerated women (Hotelling 2008; Shlafer, Gerrity & Duwe 2017). These emerging studies have shown that even though vulnerable populations could benefit the most from continuous labor support, they tend to have the least access to doula services (Hodnett, Gates, Hofmeyr & Sakala 2013). One of the most frequently discussed barriers to the access of doula care seems to be affordability and costs. Recent research studies have deemed labor doula care to be a low-cost intervention that can decrease long-term health care costs related to maternal and child health. Therefore, the reimbursement of doula care by health insurance programs, including Medicaid programs, has been suggested (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson & O'Brien 2013). Currently, only two states, Oregon and Minnesota, passed recent legislation to allow Medicaid reimbursement for doula care, nevertheless, implementation challenges were substantial (Kozhimannil, Vogelsang & Hardemann 2015).

This research study provides groundwork for understanding how labor doula care may influence the pathways between trauma-related obstetric challenges and birth outcomes and experiences of sexual abuse survivors. Considering the high prevalence and ubiquity of sexual violence and its long-term adverse health outcomes, this study may inform future advances towards financial reimbursement of doula care through health insurances as well as towards the

thorough integration of non-medical labor support as provided by doulas within the current medical maternity care system.

4.5.2 Implications for Practice

Over the past decades, childbirth has undergone a significant medicalization that prioritizes clinical and technological care and neglects rather traditional, non-medical care approaches. The majority of women now give birth in sterile, isolated environments without individualized, women-centered emotional and physical support (Leavitt 1999).

Pregnancy and childbirth can be a significant and intense time in any woman's life, and for childbearing survivors of sexual violence vulnerability and stress is often increased. Therefore, research has highlighted the significant impact of trusting doctor-patient relationships, as well as the benefits of continuous labor doula care on birth outcomes and maternal satisfaction (Gilliland 2002).

The findings of this study show that doulas can increase knowledge, agency, and connectedness to help facilitate interaction and communication between survivors of sexual abuse and their medical maternity care team. Labor doulas create a safer, trusting space where survivors can talk openly about their triggers, concerns and fears with regard to their history of trauma, pregnancy, and childbirth. This study emphasizes the women-centered care provided by doulas that engages survivors to be an active participant and agent in their maternity health care choices, therefore, improving informed consent, choice and maternal satisfaction.

4.6 LIMITATIONS

The sample used for this research was non-diverse and small as it included three women from one metropolitan, urban area of the United States. Therefore, generalizations cannot be made. The study also only captured the perspectives and insights of labor doulas. Sexual abuse survivors were not interviewed as part of this study; however, their voices are crucial to better understand how labor doula care can assist them to overcome trauma-related challenges during labor and delivery. Moreover, to ensure comprehensiveness, medical maternity care staff should also be included in this exploration of continuous labor support for survivors of sexual violence. Another limitation of the study is potential bias as the interviews were analyzed and coded by only one person.

Although the study helps to understand how doulas can assist childbearing women who have experience sexual violence and sets forth hypotheses for future research, it does not establish a causal pathway. However, this research highlights the need for further exploration and investigation of the role of non-medical, continuous labor support in addressing trauma-related challenges and preventing re-traumatization during labor and delivery as often experienced by survivors of sexual violence.

5.0 CONCLUSIONS

Labor doula support for women who have a history of sexual violence can mitigate trauma-related triggers and challenges experienced during labor and delivery, hence the likelihood of re-traumatization through childbirth may be decreased. Birth experiences and maternal satisfaction can be facilitated and improved through the individualized emotional and physical doula care that may enhance a survivor's personal security, knowledge, connectedness, respect, and agency and act as a buffer from the effects of harsh clinical environments.

Facilitating access to doula care for pregnant survivors of sexual violence who are at risk of poor birth experiences may improve the adverse short and long-term birth outcomes affecting not only the survivor, but also her child. The study contributes to research efforts highlighting doulas as a social support intervention which can improve the birth outcomes of vulnerable populations. Moreover, this study also adds to the small body of research that examines non-medical, alternative labor support for women with a history of sexual violence. More research that captures the insights and voices of survivors and medical maternity care staff is needed in order to thoroughly understand and improve the birth experiences and outcomes of survivors of sexual abuse.

BIBLIOGRAPHY

- American College of Obstetricians and Gynecologists & Society for Maternal-Fetal Medicine (2016). Obstetric Care Consensus. Safe Prevention of the Primary Cesarean Delivery. Retrieved from: <https://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery>
- American College of Obstetricians and Gynecologists (2011). Adult Manifestations of Childhood Sexual Abuse. Committee Opinion Number 498. Retrieved from: <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Adult-Manifestations-of-Childhood-Sexual-Abuse>
- Anim-Somuah M, Smyth RMD, Jones L (2011). Epidural versus non-epidural or no analgesia in labour. Cochrane Database of Systematic Reviews, Issue 12.
- American College of Emergency Physicians (1999). Evaluation and management of the sexually assaulted or sexually abused patient. Dallas, Texas. Retrieved from www.acep.org/WorkArea/DownloadAsset.aspx?id=8984
- American Psychological Association (2014). Child Sexual Abuse: What Parents Should Know. Retrieved from: <http://www.apa.org/pi/families/resources/understanding-child-abuse.aspx>
- Bartick MC & Reinhold AG (2010). The burden of suboptimal breastfeeding in the United States: A pediatric cost analysis. *Pediatrics* 125(3): 1048-1056.
- Bartick MC, Stuebe AM, Schwarz EB, Luongo C, Reinhold AG & Foster EM (2013). Cost analysis of maternal disease associated with suboptimal breastfeeding. *Obstetrics & Gynecology* 122(1): 111-119.
- Basile KC, Smith SG, Breiding MJ, Black MC & Mahendra RR (2014). Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Black M et al. (2011). The National Intimate Partner and Sexual Violence Survey: 2010 summary report. Retrieved from the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: [http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf]

- Benedict MI, Paine LL, Paine LA, Brandt D & Stallings R (1999). The association of childhood sexual abuse with depressive symptoms during pregnancy, and selected pregnancy outcomes. *Child Abuse and Neglect* 23(7): 659-670.
- Bolen RM, Scannapieco M (1999). Prevalence of child sexual abuse: a corrective meta-analysis. *Social Service Rev* 73. 281-313.
- Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.
- Bramadat IJ & Diedger M (1993). Satisfaction with childbirth: Theories and methods of measurement. *Birth* 21(1): 22-29.
- Breedlove G (2005). Perceptions of social support from pregnant and parenting teens using community-based doulas. *The Journal of Perinatal Education* 14(3): 15-22.
- Breiding MJ, Smith SG, Basile KC, Walters ML, Chen J & Merrick MT (2014). Prevalence and characteristics of sexual violence, stalking, intimate partner violence victimization in the United States – National Intimate Partner and Sexual Violence Survey, 2011. United States. *MMWR* 63(SS-8). 1-18.
- Buckley SJ (2015). *Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care*. Washington, D.C.: Childbirth Connection Programs, National Partnership for Women & Families. Retrieved from: <http://www.nationalpartnership.org/research-library/maternal-health/hormonal-physiology-of-childbearing.pdf>
- Burgess AW, ed. (2000). *Violence through a forensic lens*. King of Prussia, PA, Nursing Spectrum.
- Burian J (1995). Helping survivors of sexual abuse through labor. *MCN: The American Journal of Maternal/Child Nursing* 20(5): 252-256.
- Campbell DA, Lake MF, Falk M, Backstrand JR (2006). A randomized control trial of continuous support in labor by a lay doula. *Journal of Obstetric, Gynecological & Neonatal Nursing* 35(4): 456-464.
- Caton D, Corry MP, Frigoletto FD, Hopkins DP, Lieberman E, Mayberry L, et al. (2002). The nature and management of labor pain: executive summary. *American Journal of Obstetrics and Gynecology* 186(5): 1-15.
- Chapple W, Gilliland A, Li D, Shier E & Wright E. (2013). An Economic Model of the Benefits of Professional Doula Labor Support in Wisconsin Births. *Wisconsin Medical Journal* 112(2): 58-64

- Clarke L (1998). Perinatal Care for survivors of sexual abuse. *Nurse BC* 30(2). 9-16.
- Cook K & Loomis C (2012). The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education* 21(3): 158-168.
- Coomaraswamy R. (1997). Preliminary report submitted by the Special Rapporteur on violence against women: its causes and consequences. New York, NY, United Nations.
- Coles J, Jones K (2008). "Universal Precautions": Perinatal Touch and the Examination after Childhood Sexual Abuse. *Birth* 36(3): 230-236.
- Creanga AA, Syverson C, Seed K, Callaghan WM (2017). Pregnancy-Related Mortality in the United States, 2011-2013. *Obstetrics & Gynecology* 130(2).
- Declerq E, Sakala C, Corry M, Applebaum S, Herrlich A. (2013). Listening to Mothers III: Report of the Third National U.S. Survey of Women's Childbearing Experiences. New York: Childbirth Connection. Retrieved from:
http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf
- Duncan KA (2005). The impact of child sexual abuse on parenting; A female perspective. In GR Walz & RK Yep (Eds.) *VISTAS: Compelling perspectives on counseling*, 2005 (pp.267-270). Alexandria, VA: American Counseling Association.
- Edwards VJ, Anda RF, Felitti VJ & Dube SR (2004). Adverse childhood experiences and health-related quality of life as an adult. In KA Kendall-Tackett (Ed.) *Health consequences of abuse in the family* (1st ed. Pp. 81-94). Washington, DC: American Psychological Association.
- Egeland B, Jacobvitz D & Sroufe LA (1988). Breaking the cycle of abuse. *Child Development* (59): 1080-1088.
- Elfgren C, et al. (2017). Breastfeeding in Women Having Experienced Childhood Sexual Abuse. *Journal of Human Lactation* 33(1). 119-127.
- Finkelhor D, Hotelling G, Lewis IA, Smith C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. *Child Abuse & Neglect* 14. 19-28.
- Finkelhor D (1994). The international epidemiology of child sexual abuse. *Child Abuse and Neglect* 18(5):409-417.
- Finkelhor D (2009). The Prevention of Childhood Sexual Abuse. *Future of Children* 19(2):169-94.

- Finkelhor D, Jones L. (2012). Have Sexual Abuse and Physical Abuse Declined Since the 1990s?. Crimes Against Children Research Center, University of New Hampshire.
- Freedman LP & Kruk ME (2014). Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *The Lancet* (384). 42-43.
- Garratt L. (2002). Maternity care of survivors of sexual abuse. *MIDIRS Midwifery digest* 12(1):26-28.
- Gilliland AL (2002) Beyond Holding Hands: The Modern Role of the Professional Doula. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 31(6): 762-769.
- Gilliland AL (2010). After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada. *Midwifery* 27(4): 525-531.
- Goer H & Romano A (2012). Optimal Care in childbirth: The case for a physiologic approach. Seattle, WA. Classic Day.
- Groth AN. The rapist's view. In: Burgess AW, ed. *Violence through a forensic lens*. King of Prussia, PA, Nursing Spectrum, 2000.
- Gruber KJ, Cuptio SH, Dobson CF (2013). Impact of Doulas on Healthy Birth Outcomes. *The Journal of Perinatal Education* 22(1): 49-58.
- Hardin AM & Buckner EB (2004). Characteristics of a positive experience for women who have unmedicated childbirth. *The Journal of Perinatal Education* 13(4): 10-16.
- Haugaard JJ (2000). The challenge of defining child sexual abuse. *American Psychologist* 55(9): 1036-1039.
- Heritage C (1998). Working with childhood sexual abuse survivors during pregnancy, labor and birth. *JOGNN* 27(6). 671-677.
- Herman J (1997). Trauma and Recovery. The Aftermath of Violence – From Domestic Abuse to Political Terror. Basic Books. New York, NY.
- Hilden M, Sidenius K, Langhoff-Roos J, Wijma B & Schei B (2003). Women's experiences of the gynecological examination: Factors associated with discomfort. *Acta Obstetrica et Gynecologica Scandinavica* 82: 1030-1036.
- Hodnett ED (2002). Pain and women's satisfaction with the experience of childbirth: a systematic review. *American Journal of Obstetrics and Gynecology* 186(5): 160-172.
- Hodnett ED, Gates S, Hofmeyr G & Sakala C. (2013). Continuous Support for Women During Childbirth (Review). *Cochrane Database of Systematic Reviews*.

- Hofmeyr G, Nikodem VC, Wolman WL, Chalmers BE & Kramer T (1991). Companionship to modify the clinical birth environment: effects on progress and perceptions of labour and breastfeeding. *BJOG* 98(8): 756-764.
- Hogan VK, Shanahan ME & Rowley DL (2011). Reducing Racial/Ethnic Disparities in Reproductive and Perinatal Outcomes. Handler A, Kennelly J & Peacock N, editors.
- Hotelling BA (2008). Perinatal Needs of Pregnant, Incarcerated Women. *Journal of Perinatal Education* 17(2). 37-44.
- Jacobs JL (1992). Child sexual abuse victimization and later sequelae during pregnancy and childbirth. *Journal of Child Sexual Abuse* 1(1): 103-112.
- Jordan C (2013). Therapeutic presence and continuous labor support. In *Best Practices in Midwifery: Using the Evidence to Implement Change*. Ed by Anderson BA & Stone S. Springer Publishing Company; New York, NY.
- Kabakian-Khasholian T, El-Nemer A, Bashour H (2015). Perceptions about labor companionship at public teaching hospitals in three Arab countries. *International Journal of Gynecology & Obstetrics* 129(3): 223-226.
- Kilpatrick D et al. (2007). Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study. [<https://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf>]
- Kitzinger JV (1992). Counteracting, not reenacting the violation of women's bodies: The challenge of perinatal caregivers. *Birth* 19(4). 219-220.
- Kitzinger S (2012). Rediscovering the Social Model of Childbirth. *Birth* 39(4): 301-304.
- Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C & O'Brien M (2013). Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American Journal of Public Health* 103(4). 113-121.
- Kozhimannil KB, Vogelsang CA, Hardeman RR & Prasad S (2016). Disrupting the pathways of social determinants of health: doula support during pregnancy and childbirth. *The Journal of the American Board of Family Medicine* 2016 29(3): 308-317.
- Kozhimannil KB, Vogelsang CA & Hardeman RR (2015). Medicaid Coverage of Doula Services in Minnesota: Preliminary findings from the first year. Interim Report to the Minnesota Department of Human Services.
- Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C & O'Brien M (2013). Doula Care, Birth Outcomes, and Costs among Medicaid Beneficiaries. *American Journal of Public Health* 103(4): 113-121.

- Lasiuk GC (2007). The lived experience of pregnancy and birthing of women with histories of childhood sexual abuse. Doctoral thesis. University of Alberta, Edmonton, Canada.
- Leavitt JW (1999). Women and health in America: historical readings. University of Wisconsin Press.
- Lederman E, Lederman RP, Work BA Jr, McCann DS (1981). Maternal psychological and physiologic correlates of fetal-newborn health status. *American Journal of Obstetrics and Gynecology* 139(8): 956-958.
- Leeb RT, Paulozzi LJ, Melanson C, Simon TR & Arias I (2008). Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
- Leeners B, Richter-Appelt H, Imthurn B, and Rath W (2006). Influence of childhood sexual abuse on pregnancy, delivery and the early postpartum period in adult women. *Journal of Psychosomatic Research* 61(2). 139-151.
- Leeners B, Stiller R, Block E, Gorres BI & Rath W (2007). Effect of childhood sexual abuse on gynecologic care as an adult. *Psychosomatics* 48: 385-393.
- Leeners B. et al. (2010). Pregnancy complications in women with childhood sexual abuse experiences. *Journal of Psychosomatic Research* 69: 503-510.
- Leeners B, Rath W, Block E, Goerres G & Tschudin S (2014). Risk factors for unfavorable pregnancy outcome in women with adverse childhood experiences. *Journal of Perinatal Medicine* 42(2): 171-178.
- Liu S, Liston RM, Joseph KS, Heaman M, Sauve R & Kramer MS (2007). Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. *Canadian Medical Association Journal* 176(4): 455-460.
- LoGiudice JA, Beck CT (2016). The Lived Experiences of Childbearing From Survivors of Sexual Abuse: “It was the Best of Times, It Was the Worst of Times”. *Journal of Midwifery and Women’s Health* 61(4): 478-481.
- Lukasse M. et al. (2009). Childhood abuse and common complaints in pregnancy. *Birth* 36(3): 190-199.
- Lyerly AD (2013). A good birth: finding the positive and profound in your childbirth experience. Penguin.

- Maheux B, Haley N, Rivard M & Gervais A (1999). Do physicians assess lifestyle health risks during general medical examinations? A survey of general practitioners and obstetrician-gynecologists in Quebec. *Canadian Medical Association Journal* 160: 1830-1834.
- Main M (1996). Introduction to the special section on attachment and psychopathology: Part II. Overview of the field of attachment. *Journal of Consulting and Clinical Psychology* 64(2): 5-7.
- Martin E, Silverstone P (2013). How much Child Sexual Abuse is “Below the Surface”, and can we Help Adults Identify it Early? *Frontiers in Psychiatry* 4(58).
- Martin JA, Hamilton BE, Ventura SJ, Osterman MJ, Curtin SC & Mathews TJ (2013). Births: Final data for 2012. *National Vital Statistics Report*, 62(9). 1-87.
- Marysko M, Reck C, Mattheis V, Finke P, Resch F & Moehler E (2010). History of Childhood Abuse is Accompanied by Increased Dissociation in Young Mothers Five Months Postnatally. *Psychopathology* 43: 104-109.
- McGrath SK, Kennell JH (2008). A randomized controlled trial of continuous labor support for middle-class couples: effect on Cesarean delivery rates. *Birth* 25(3): 92-97.
- McGregor K (2003). Therapy – It is a two-way thing: Women survivors of child sexual abuse describe their therapy experiences. Unpublished doctoral thesis. University of Auckland, Auckland, New Zealand.
- Miller TR, Cohen MA, Wiersema B. (1996). Victim costs and consequences: A new look. Retrieved from the U.S. Department of Justice, Office of Justice Programs, National Institute of Justice: [<https://www.ncjrs.gov/pdffiles/victcost.pdf>]
- Montgomery E (2013). Feeling safe: A metasynthesis of the maternity care needs of women who were sexually abused in childhood. *Birth* 40(2): 88-95.
- Mottl-Santiago J., Walker C., Ewan J., Vragovic O., Winder S., & Stubblefield P. (2007). A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. *Maternal and Child Health Journal*, 12(4), 372–377
- Newton K. N., Chaudhuri J., Grossman X., & Merewood A. (2009). Factors associated with exclusive breastfeeding among Latina women giving birth at an inner-city baby friendly hospital. *Journal of Human Lactation*, 25(1), 28–32
- Nerum H. et al (2010). Birth outcomes in primiparous women who were raped as adults: a matched controlled study. *BJOG* 2010;117. 288-294.
- Noll JG, Trickett PK, Harris WW & Putnam FW (2009). The Cumulative Burden Borne by Offspring Whose Mothers Were Sexually Abused as Children: Descriptive Results From a Multigenerational Study. *Journal of Interpersonal Violence* 24(3): 424-449.

- Parratt J (1994). The experience of childbirth for survivors of incest. *Midwifery* 10(1): 26-39.
- Peschers UM, Du Mont J, Jundt K, Pfurtner M, Dugan E & Kindermann G (2003). Prevalence of sexual abuse among women seeking gynecologic care in Germany. *Obstetrics & Gynecology* 101: 103-108.
- Polusny M & Follette V (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied and Preventive Psychology* (4): 143-166.
- Read J, McGregor K, Coggan C & Thomas DR (2006). Mental health services and sexual abuse: The need for staff training. *Journal of Trauma and Dissociation* 7(1): 33-50.
- Roberts AL, Chen Y, Slopen N, McLaughlin KA, Koenen KC & Austin SB (2015). Maternal Experience of Abuse in Childhood and Depressive Symptoms in Adolescent and Adult Offspring: A 21-year Longitudinal Study. *Depression and Anxiety* 32(10): 709-719.
- Romano AM & Lothian JA (2008). Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 37(1): 94-105.
- Rennison CA (2002). Rape and sexual assault: Reporting to police and medical attention, 1992-2000. Retrived from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: [<http://bjs.ojp.usdoj.gov/content/pub/pdf/rsarp00.pdf>]
- Rhodes N & Hutchinson S (1994). Labor experiences of childhood sexual abuse survivors. *Birth* 21(4). 213-220.
- Rouf K. (1999). Child sexual abuse and pregnancy: a personal account. *The Practicing Midwife* 2(6). 29-3.
- Schachter C et al. (2004) Women survivors of child sexual abuse. How can health professionals promote healing? *Canadian Family Physician* 50: 405-412.
- Schore A (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal* 22: 201-269.
- Seng JS, Hassinger JA (1998). Relationship strategies and interdisciplinary collaboration. Improving maternity care with survivors of childhood sexual abuse. *Journal of Nurse Midwifery* 43(4). 287-295.
- Seng J., Sparbel K., Low L. and Killion C. (2002) Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. *Journal of Midwifery & Women's Health* 47(5):360-370.

- Shlafer RJ, Gerrity E & Duwe G (2017). Pregnancy and Parenting Support for Incarcerated Women: Lessons Learned. *Progress in Community Health Partnerships* 9(3): 371-378.
- Snyder H (2000). Sexual Assault of Young Children as Reported to Law Enforcement: Victim, Incident, and Offender Characteristics. U.S. Department of Justice. Bureau of Justice Statistics.
Retrieved from: <https://www.bjs.gov/content/pub/pdf/saycrle.pdf>
- Simkin P. (1992). Just another day in a Woman's life? Part II: Nature and Consistency of Women's Long-Term Memories of their first birth experiences. *Birth* 19(2)
- Simkin P., Klaus P. (2004). When survivors give birth. Understanding and Healing the Effects of Early Sexual Abuse on Childbearing women. Classic Day Publishing. Seattle, WA.
- Simpkins R. (2006). The effects of sexual abuse on childbearing: Antenatal care. *British Journal of Midwifery* 14(3). 162-163.
- Singh GK (2010). Maternal Mortality in the United States 1935-2007: Substantial racial/ethnic, socioeconomic, and geographic disparities persist. Washington, DC: U.S. Department of Health and Human Services.
- Strauss N, Giessler K, McAllister E (2015). Doula care in New York City: Advancing the goals of the Affordable Care Act. *The Journal of Perinatal Education* 24(1): 8-15.
- Ulin PR, Robinson ET & Tolley EE (2004). *Qualitative Methods in Public Health: A Field Guide for Applied Research*: Jossey-Bas.
- United Nations Interregional Crime and Justice Research Institute (1998). *Victims of crime in the developing world*. Rome, Italy.
- United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2016). *Child Maltreatment Survey 2015*.
Retrieved from: <https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf>
- Van der Kolk B (2014). *The body keeps the score. Brain, mind, and body in the healing of trauma*. Penguin Books. New York, NY.
- Wagner M (2006). *Born in the USA. How a broken maternity care system must be fixed to put women and children first*. University of California Press, Berkeley, CA.
- Weiss AJ, Elixhauser A & Andrews RM (2014). Characteristics of operating room procedures in U.S. hospitals, 2011. Rockville, MD: Agency for Healthcare and Quality. Retrieved from: <https://hcup-us.ahrq.gov/reports/statbriefs/sb170-Operating-Room-Procedures-United-States-2011.jsp>

- World Health Organization (2015). WHO recommendations for augmentation of labour. Retrieved:
http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363_eng.pdf?ua=1
- World Health Organization (2016). Standards for improving quality of maternal and newborn care in health facilities. Retrieved:
<http://apps.who.int/iris/bitstream/10665/249155/1/9789241511216-eng.pdf?ua=1>
- White A (2004). Responding to prenatal disclosure of past sexual abuse. *Obstetrics & Gynecology* 123(6):1344-1347.
- Wijma B, Schei B, Swahnberg K, Hilden M, Offerdal K, Pikarinen U et al. (2003). Emotional, physical, and sexual abuse in patients visiting gynecology clinics: a Nordic cross-sectional study. *Lancet* 361: 2107-2113.
- World Health Organization (1999). Report of the consultation on child abuse prevention (WHO/HSC/PVI/99.1) World Health Organization; Geneva (Switzerland): Retrieved from <http://apps.who.int/iris/handle/10665/65900>
- World Health Organization (2003). Guidelines for medico-legal care for victims of sexual violence. World Health Organization; Geneva (Switzerland): Retrieved from <http://apps.who.int/iris/bitstream/10665/42788/1/924154628X.pdf>